ESSENTIAL PLAN SECTION XXV – EMPIRE BLUECROSS BLUESHIELD HEALTHPLUS SCHEDULE OF BENEFITS

*See **Benefit description** in contract for more details.

Participating Provider services are not covered for any services other than those related to emergency care and you pay the full cost for services performed by a nonparticipating provider except in cases related to emergency care.

COST-SHARING	ESSENTIAL PLAN 3
Deductible • Individual	$0
Out-of-pocket limit • Individual Deductibles, coinsurance and copays that make up your out-of-pocket limit accumulate on a plan year basis.	$200
OFFICE VISITS	
Primary care office visits (or home visits)	$0
Specialist office visits (or home visits)	$0
PREVENTIVE CARE	
• Adult annual physical examinations*	Covered in full
• Adult immunizations*	Covered in full
• Routine gynecological services/well woman exams*	Covered in full
• Mammography screening and diagnostic imaging for the detection of breast cancer*	Covered in full
• Sterilization procedures for women*	Covered in full See **Surgical services section**
• Vasectomy	Covered in full
• Bone density testing*	

• Screening for prostate cancer
  • Performed in PCP office
 	
  • Performed in specialist office
• All other preventive services required by USPSTF and HRSA
 	
• *When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA
	$0
	
	$0
	
	Covered in full
	
	Use cost-sharing for appropriate service (primary care office visit; specialist office visit; diagnostic radiology services; lab procedures and diagnostic testing)

EMERGENCY CARE	
Pre-hospital emergency medical services (ambulance services)	$0
Nonemergency ambulance services	$0 **See contract on how to use this service**
Emergency department Copay/Coinsurance waived if hospital admission	$0
Urgent care center	$0 **Preauthorization required for out-of-network urgent care**
PROFESSIONAL SERVICES and OUTPATIENT CARE	
Advanced imaging services • Performed in a freestanding radiology facility or office setting • Performed as outpatient hospital services **Preauthorization required**	 $0 $0 **Preauthorization required**
Allergy testing and treatment • Performed in a PCP office	 $0

• Performed in a specialist office	$0
Ambulatory surgical center facility cee	$0
Anesthesia services (all settings)	Covered in full
Autologous blood banking	Covered in full
Cardiac and pulmonary rehabilitation • Performed in a specialist office • Performed as outpatient hospital services • Performed as inpatient hospital services	 $0 $0 Included as part of inpatient hospital service cost-sharing
Chemotherapy • Performed in a PCP office • Performed in a specialist office • Performed as outpatient hospital services	 $0 $0 $0
Chiropractic Services	$0 **Preauthorization required after the first five visits**
Clinical trials	Use cost-sharing for appropriate service **Preauthorization required**
Diagnostic testing • Performed in a PCP office • Performed in a specialist office	 $0 $0

• Performed as outpatient hospital services	$0
Dialysis • Performed in a PCP office • Performed in a freestanding center or specialist office setting • Performed as outpatient hospital services	 $0 $0 $0
Habilitation services (physical therapy, occupational therapy or speech therapy)	$0 20 visits per therapy per plan year
Home health care 40 visits per plan year	$0 **Preauthorization required**
Infertility services	Use cost-sharing for appropriate service (office visit; diagnostic radiology services; surgery; lab & diagnostic procedures)
Infusion therapy • Performed in a PCP office • Performed in specialist office • Performed as outpatient hospital services • Home infusion therapy (Home infusion counts toward home health care visit limits)	 $0 $0 $0 $0
Inpatient medical visits	$0 per admission **Admission preauthorization required**

Lab procedures • Performed in a PCP office • Performed in a freestanding lab facility or specialist office • Performed as outpatient hospital services	 $0 $0 $0
Maternity and newborn care • Prenatal care • Inpatient hospital services and birthing center • Physician and midwife services for delivery • Breast pump • Postnatal care	 $0 $0 $0 $0 Included in physician and midwife services for delivery cost-sharing **Preauthorization required for inpatient services breast pump**
Outpatient hospital surgery facility charge	$0
Preadmission testing	$0
Diagnostic radiology services • Performed in a PCP office • Performed in a freestanding radiology facility or specialist office • Performed as outpatient hospital services	 $0 $0 $0
Therapeutic radiology services • Performed in a freestanding radiology facility or specialist office	 $0

• Performed as outpatient hospital services	$0 **Preauthorization required**
Rehabilitation services (physical therapy, occupational therapy or speech therapy)	$0 20 visits per therapy per plan year **Preauthorization required**
Second opinions on the diagnosis of cancer, surgery and other	$0 **Preauthorization required**
Surgical services (including oral surgery; reconstructive breast surgery; other reconstructive and corrective surgery; transplants; and interruption of pregnancy) **All transplants must be performed at designated facilities**	
• Inpatient hospital surgery	$0
• Outpatient hospital surgery	$0
• Surgery performed at an ambulatory surgical center	$0
• Office surgery	$0 **Preauthorization required**
Telemedicine program	$0
ADDITIONAL SERVICES, EQUIPMENT and DEVICES	
ABA treatment for autism spectrum disorder	$0 **Preauthorization required**
Assistive communication devices for autism spectrum disorder	$0 **Preauthorization required**

Diabetic equipment, supplies and self-management education • Diabetic equipment, supplies and insulin (30-day supply) • Diabetic education	 $0 $0
Durable medical equipment and braces	$0 **Preauthorization required**
External hearing aids **(Single purchase one every three years)**	$0 **Preauthorization required**
Cochlear implants **(One per ear per time covered)**	$0 **Preauthorization required**
Hospice care • Inpatient • Outpatient 210 days per plan year Five visits for family bereavement counseling	 $0 $0 **Preauthorization required**
Medical supplies	$0
Prosthetic devices • External One prosthetic device, per limb, per lifetime, and the cost of repair and replacement of the prosthetic devices and its parts • Internal	 $0 Included as part of inpatient hospital cost-sharing **Preauthorization required**
INPATIENT SERVICES and FACILITIES	

Inpatient hospital for a continuous confinement (including an inpatient stay for mastectomy care, cardiac and pulmonary rehabilitation, and end of life care).	$0 **Preauthorization required. However, preauthorization is not required for emergency admissions.**
Observation stay Copay waived if direct transfer from outpatient surgery setting to observation	$0
Skilled nursing Facility (including cardiac and pulmonary rehabilitation) 200 days per plan year Copay waived for each admission if directly transferred from hospital inpatient setting to skilled nursing facility	$0 **Preauthorization required**
Inpatient habilitation services (physical, speech and occupational therapy) 60 days per plan year combined therapies	$150 **Preauthorization required**
Inpatient rehabilitation services (physical, speech and occupational therapy) 60 per plan year combined	$0 **Preauthorization required**
MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES	
Inpatient mental health care (for a continuous confinement when in a hospital)	$0 **Preauthorization required. However, preauthorization is not required for emergency**

	admissions.
Outpatient mental health care (including partial hospitalization and intensive outpatient program services)	$0 **Preauthorization required**
Inpatient substance use services (for a continuous confinement when in a hospital)	$0 **Preauthorization required. However, preauthorization is not required for emergency admissions or for participating OASAS-certified facilities.**
Outpatient substance use services	$0 **Preauthorization required**
PRESCRIPTION DRUGS	
Retail pharmacy	
30-day supply Tier 1 Tier 2 Tier 3	 $1 $3 $3
Up to a 90-day supply for maintenance drugs Tier 1 Tier 2 Tier 3	 $30 $3 $3 Non-participating provider services are not covered and you pay the full cost
Mail order pharmacy	
Up to a 90-day supply Tier 1 Tier 2 Tier 3	 $3 $8 $8

	Non-participating provider services are not covered and you pay the full cost
Enteral formulas Tier 1 Tier 2 Tier 3	 $1 $3 $3
NONPRESCRIPTION DRUGS	$.50
WELLNESS BENEFITS	
Gym reimbursement	Up to $200 per six-month period
DENTAL and VISION CARE	
Dental care • Preventive dental care • Routine dental care • Major dental (endodontics, periodontics and prosthodontics, One dental exam and cleaning per six-month period. Full mouth X-rays or panoramic X-rays at 36-month intervals and bitewing X-rays at six to 12-month intervals **Orthodontics and major dental require preauthorization**	 $0 $0 $0 **Orthodontics and major dental require preauthorization**

Vision care • Exams • Lenses and frames • Contact lenses One exam per 12-month period; plan year One prescribed lenses and frames per plan year	 $0 $0 $0 **Contact lenses require preauthorization**

All in-network preauthorization requests are the responsibility of your participating provider. You will not be penalized for a participating provider's failure to obtain a required preauthorization. However, if services are not covered under contract, you will be responsible for the full cost of the services.